The Pennsylvania
Psychologist
SEPTEMBER 2023
VOLUME 83, NUMBER 7

THE NEW DRUGS

EARN **1 CE CREDIT** FOR THIS ISSUE!

WHAT'S INSIDE

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PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION
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VOLUME 83, NUMBER 7 SEPTEMBER 2023

The Pennsylvania Psychologist is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in *The Pennsylvania Psychologist* represent the opinions of the individual writers and do not necessarily represent the opinion or consensus of opinion of the governance or members or staff of PPA or PPF.

If you are interested in submitting an article to be published in *The Pennsylvania Psychologist* please contact Publications Chairperson, Helena Tuleya-Payne, DEd at *publications@papsy.org.*

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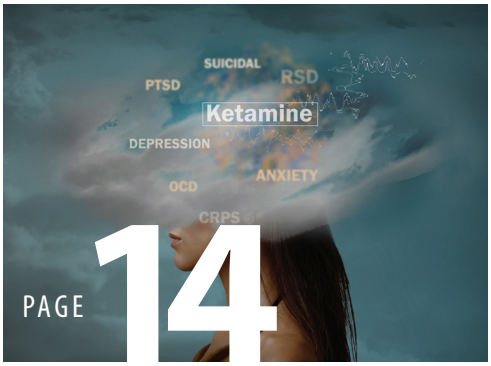

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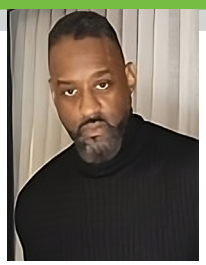

FOCUS OF THE YEAR

TIM BARKSDALE, PsyD

For my presidential speech, given at the 2023 PPA Annual Convention, I outlined the initiatives for the upcoming year. Here is a recap of the content and some of the events of the evening. I have stated many times how honored I am to serve as president of this great association. What was interesting is that amongst the many congratulatory greetings and best wishes received over the year, a few people erroneously congratulated me for being the first president of color or the only Black male to serve in the role. To address that and to express appreciation for the pioneers that came before me, I acknowledged past presidents: Drs. Anita Brown, Melvin Rogers, Dianne Salter, and Beatrice Salter. Because of these giants, I am not the "first" or the "only;" I can proudly say that I am simply the 56th president of the Pennsylvania Psychological Association. In recognition of the 55 others who held this position, the formation of the Presidential Special Interest Group was identified. This group has monthly virtual meetings to reminisce, network, and respond to select questions designed to orient the president and president-elect to the position, as well as to provide information to current and new members about the joys and benefits of being a part of one of the largest and most substantial state psychological associations in America.

Along with ensuring that the 2024 Annual Convention provides a fun, safe, and welcoming environment for all, my initiatives for the upcoming year include educating the field of psychology on how to provide quality mental health services to people with physical and or intellectual disabilities, covert mentorship to students and early career psychologists (ECPs), and the continuation of the "Each One, Reach One" initiative I named for recruiting new PPA members. Past president Dr. Mark Hogue asked me how I felt about making the speech. I jokingly told him that I felt woefully inadequate when comparing my three initiatives to him legendarily identifying well over 10 initiatives at his presidency. He laughed and responded, "well-played." He can thank past president Dr. David Palmiter for arming me with that information.

For my major initiative, "Access Ability, Making Psychology Accessible to All," the concept of disability has been a part of my life since the age of 3, when my brother was born with cerebral palsy. The lack of medical or societal investment in people with disabilities was immediately evident when my mother was instructed to leave my brother at the hospital because he would either die within days or, if he survived, would be best served in an institution. My mother refused the advice and brought my brother home, and we celebrated when he rolled over days later, with the signature smile he still has today. Although he had full cognitive ability, growing up was significantly challenging with his speech difficulties and impaired walking, and his tremors making it hard to feed himself or hold a cup. However, because my mother insisted on raising him with the same expectations that she had for me and my two sisters, my brother grew up to graduate from high school, be employed for over 40 years, own a home, and raise a child of his own. Growing up with him and his peers propelled me into a special education major before returning to school years later for psychology. Because of that background when I did my practicum and internship in psychiatric hospitals and community health centers, it was painfully obvious that psychologists and psychiatrists lacked training and experience in providing treatment to people who were disabled, especially concerning people with intellectual disabilities. I have formed a Disability Advocacy Special Interest Group that invites professionals with disabilities, those who work with this community, and other advocates to discuss experiences, write articles, and assist in the planning of the 2024 Convention in Lancaster June 12–15. In 2012, I did my dissertation on the treatment disparity for adults with intellectual and developmental disabilities. PPA is supporting a follow-up study for which I will share the results at our 2024 Convention. If you have not completed the survey, please do so now with this link: https://www.surveymonkey.com/r/NLFT9N5.

My second initiative, Covert Mentorship, is a term I coined several years ago based on all the support I received as a student and ECP from past president Dr. Jeanne Slattery. Without really knowing me and without ever discussing a mentor relationship, Jeanne presented me with opportunities to cowrite articles and copresent at workshops, nominated me for awards, and even allowed me to sit in on a board meeting in her absence. Because of these actions, she can take at least partial credit for me being in PPA leadership today. I invite all members to take this example and apply it to students and ECPs whenever you have the opportunity. This step can only build a stronger community and assure a strong legacy for the future of psychology.

For the final initiative, Each One, Reach One, I look forward to working with PPA executive director Ann Marie Frakes and Membership Chair Dr. Williametta Simmons in increasing the number of members by finding the 3000+ licensed psychologists and thousands of psychology students and

(Continued on page 6)

THE ART OF CULTIVATING A THRIVING ONLINE COMMUNITY LIKE *MYPPA*

ANN MARIE FRAKES, MPA

In today's digital era, online communities have become a crucial aspect of professional associations, fostering engagement, knowledge sharing, and networking among like-minded individuals. However, growing a successful online community is not an instantaneous process; it demands time, dedication, and strategic efforts. This article explores the reasons why building and nurturing an online community for a professional association like PPA requires time to develop and thrive.

1. ESTABLISHING TRUST AND CREDIBILITY

One of the fundamental building blocks of a successful online community is trust. Trust cannot be earned overnight; it is cultivated over time through consistent engagement, valuable contributions, and transparent communication. For a professional association, gaining members' trust is paramount to ensure active participation and a sense of belonging. By gradually showing expertise, addressing members' concerns, and consistently providing valuable content, the association can foster a trustworthy environment within its online community.

2. FOSTERING A SENSE OF COMMUNITY

Community building is an organic process that takes time to unfold. Members need to feel a sense of connection and belonging to engage actively within the online community. This requires nurturing relationships, encouraging discussions, and creating opportunities for members to interact. With time and effort, the community becomes a safe space where members feel comfortable sharing their experiences, insights, and challenges.

3. BUILDING MOMENTUM AND ENGAGEMENT

Attracting and keeping members in an online community can be challenging initially. It takes time for individuals to discover and join the community, and even more time to become actively involved. Early adopters and influencers play a crucial role in establishing momentum and stimulating engagement. Gradually, as the community gains traction, word-of-mouth and positive experiences of existing members can lead to organic growth.

4. DEFINING AND REFINING PURPOSE

A successful online community needs a clear purpose and direction. Identifying the community's objectives, target audience, and value proposition requires careful consideration and may evolve over time. Member feedback, analytics, and ongoing evaluation are essential in refining the community's purpose to ensure its relevance and effectiveness.

5. MANAGING CHALLENGES AND CONFLICT

With diverse opinions and personalities in an online community, conflicts and challenges are bound to arise. Addressing these issues effectively requires patience and time. Constructive moderation and mediation, along with setting clear community guidelines, are vital to maintain a positive and respectful atmosphere. As time passes, members become more familiar with the community's norms, leading to a reduction in conflicts.

6. CULTIVATING CONTENT AND KNOWLEDGE

Sustaining member interest in an online community relies heavily on the quality and relevance of the content shared. It takes time to build a repository of valuable resources, discussions, and insights. As more members join and contribute, the community's knowledge base expands, creating a valuable resource for all members.

In conclusion, growing a successful online community for a professional association is a gradual process that demands time and dedication. Building trust, fostering a sense of community, engaging members, defining purpose, managing challenges, and cultivating content are all essential aspects that take time to develop. Patience, consistent effort, and a commitment to providing value to members will ultimately lead to a thriving online community, creating a positive and impactful space for all its participants. Join us on myPPA and try it out! You might be pleasantly surprised!

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

October 5-6, 2023

PPA VIRTUAL FALL CONFERENCE

THURSDAY, OCTOBER 5

W01 - 9:00 a.m. - 12:00 p.m.
Ethics and Risk Management When Your Client Is Involved in Family Law Issues
Presenters: Steven Cohen, PhD; Jane Iannuzzelli, MEd
3 CE Credits

W02 - 12:15 p.m. - 2:15 p.m.
Act 31: Child Abuse Recognition and Reporting
Presenters: Rachael Baturin, MPH, JD; Molly Cowan, PsyD
2 CE Credits

W03 - 2:30 p.m. - 4:00 p.m.
Caring for Others Without Losing Yourself: A Compassion-Oriented Approach to Self-Care
Presenters: Jeff Sternlieb, PhD; Samuel Knapp, EdD, ABPP
1.5 CE Credits

W04 - 4:30 p.m. - 6:00 p.m.
Centering Marginalized Voices in Psychological Training Settings
Presenters: Camilo Posada Rodriguez, BA; Sara Albrecht Soto, MS; Roua Daas, BA; Jasmine A. Mena, PhD; Jose Angel Soto, PhD; Sreelakshmi Pushpanadh, MS
1.5 CE Credits

FRIDAY, OCTOBER 6

W05 - 9:00 a.m. - 12:00 p.m.
A Complex History: Racial Bias in Medicine and Psychology
Presenters: Tanya Vishnevsky, PhD; Jade Logan, PhD, ABPP; Molly Cowan, PsyD; Tyshawn Thompson, MA
3 CE Credits

W06 - 12:30 p.m. - 1:30 p.m.
The Safety Planning Intervention to Reduce Suicide Risk
Presenter: Gregory Brown, PhD
1 CE Credit

W07 - 2:00 p.m. - 5:00 p.m.
Talking With Clients About Guns: Integrating Diverse Perspectives
Presenters: Scott Romeika, PsyD; David Zehrung, PhD
3 CE Credits

Register online now at www.papsy.org

Workshop Pricing

	PPA Member	Non-Member
W01 - Ethics and Risk Management When Your Client Is Involved in Family Law Issues (3 CE)	$75.00	$150.00
W02 - Act 31: Child Abuse Recognition and Reporting (2 CE)	$50.00	$100.00
W03 - Caring for Others Without Losing Yourself: A Compassion-Oriented Approach to Self-Care (1.5 CE)	$37.50	$75.00
W04 - Centering Marginalized Voices in Psychological Training Settings (1.5 CE)	$37.50	$75.00
W05 - A Complex History: Racial Bias in Medicine and Psychology (3 CE)	$75.00	$150.00
W06 - The Safety Planning Intervention to Reduce Suicide Risk (1 CE)	$25.00	$50.00
W07 - Talking With Clients About Guns: Integrating Diverse Perspectives (3 CE)	$75.00	$150.00

CONTINUING EDUCATION CREDITS

The 2023 Virtual Fall Conference is sponsored by the Pennsylvania Psychological Association and will provide up to 15 CE credits. The Pennsylvania Psychological Association is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. More information is available online.

PPA's Act 31 program is approved by the Department of Human Services (formerly the Department of Public Welfare) and the Department of State to offer the 2 continuing education credits needed to fulfill the child abuse requirement. PA CE Provider Number: CACE000007

WHAT PSYCHOLOGISTS SHOULD KNOW ABOUT LICENSE RENEWAL

MOLLY COWAN, PsyD

In Pennsylvania, all full psychology licenses run on the same renewal cycle: December 1 of an odd-numbered year to November 30 of the next odd-numbered year. By the end of September (i.e., approximately 60 days prior to the end of the licensure cycle), the State Board of Psychology will send renewal notices via email. Previously, those emails have come from the address "RA-STPALSNOTIFY@pa.gov" with the subject line "Attention: Commonwealth of PA State Board of Psychology Update." It is important to note that psychologists will receive the email at the email address on file with the State Board of Psychology. If you need to see what email address is on file and/or update your email address, you can do so at https://www.pals.pa.gov.

Once the renewal period opens, you will return to https://www.pals.pa.gov and enter your User ID (which will be included in your renewal email). If you do not remember your password, you can use the registration code included in the email to recover your password through the PALS site. After you are logged in, click the "Renew" box in the toolbar located at the top of your screen. There will be a pop-up message with additional information, and then you just need to follow the steps to complete the renewal process. The renewal fee must be paid at the time of renewal. You will receive a confirmation email once your license has been successfully renewed. If there are any issues with your renewal, you will receive an email from the Board addressing what needs to be completed for your license to be renewed.

As part of the renewal process, you must indicate whether you completed your required continuing education (CE) credits. You do not have to submit copies of your CE certificates unless you are selected for auditing, which typically happens shortly after the start of the next biennium (i.e., December 2023–January 2024). Psychologists must complete 30 CE credits each renewal cycle, which includes 3 ethics credits, 2 child abuse reporting (Act 31) credits, and 1 suicide prevention credit.

There has been some confusion regarding whether CE must be completed in person. Some of the confusion likely came from the COVID-19 waivers that used different wording than the State Board does regarding CE. The COVID-19 waivers have expired, which means that we revert to standard regulations, and that for the current biennium and beyond, only up to 15 credits may be completed via home study courses. However, the State Board considers webinars that are live with the ability to interact with the instructor (e.g., a Zoom webinar you attend in real time with a chat or Q&A feature) as equivalent to in-person events. There is no requirement that psychologists attend in-person CE; the requirement is that no more than 15 of the required credits may be completed via home study (i.e., courses you complete asynchronously on your own that include an assessment component) (PA State Board of Psychology, 2022).

Your continuing education credits must be dated within the current biennium unless you are using carryover credits. Psychologists may carry over up to 10 hours in excess of the 30 from the immediately preceding biennium; although carryover credit cannot be used to fulfill ethics, suicide, or child abuse reporting requirements.

For the required specialized topics, to count as ethics credit, the word ethics or a derivative (e.g., ethical, ethically) must be in the title or the course completion certificate

must specify it counts toward ethics credit hours. Similarly, for the suicide prevention credits, the word suicide or a derivative must appear in the title or the completion certificate must specifically state the course counts toward suicide prevention credits. While some courses meet the requirements for both ethics and suicide prevention, psychologists can only count a course toward one of the requirements (ethics credits OR suicide prevention credits), not both. Child abuse recognition and prevention credits must be from an approved Act 31 provider; those credits will be sent directly to the State Board from the CE provider, so the provider will require your license number. You can verify the credits were sent to the state by logging into your account in the PALS system. Please note, there is often a delay of 24 hours or more from the time you complete your course until the State Board receives verification. So, it is highly recommended that you complete your Act 31 course well before the renewal deadline, as your renewal will NOT process without this verification.

Psychologists should be sure that CE credits come from providers approved by the State Board of Psychology. According to 49 Pa.Code §41.59 (d)(3), approved sponsors include accredited universities (as long as the course relates to the practice of psychology and generates semester/quarter credit), American Psychological Association (APA) and APA-approved sponsors (including PPA), sponsors approved by the American Medical Association that directly relate to the practice of psychology, and other sponsors approved by the Board on a biennial basis (PA Board of Psychology, 2021).

There are several other ways to earn CE credit approved by the State Board. These include completing a college course that has a PSY prefix and generates credit hours, teaching at a regionally accredited college, presenting CE workshops for approved sponsors, and professional writing. Psychologists may earn up to 15 CE hours each biennium through teaching but may only receive credit for the same course or workshop once every 4 years. If there are multiple instructors, the amount of CE for each instructor is determined by dividing the overall number of CE hours by the number of instructors (e.g., a 3-hour workshop presented by three people would be 1 CE hour per instructor). There are also specific guidelines for what counts as professional writing (PA State Board of Psychology, 2022).

Some additional words of advice: (1) Don't wait until the last minute to complete your required CE, and be sure to double check the math to ensure you have met your requirements; (2) don't wait until the last minute to process your renewal in case you run into any issues; and (3) don't hesitate to reach out to PPA staff with questions about or help with the renewal process!

REFERENCES

49 Pa.Code §41.59. Continuing education.

Pennsylvania State Board of Psychology. (2021). *Board approved continuing education sponsors/providers*. https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Psychology/Documents/Applications%20and%20Forms/Non-Application%20Documents/PsychM%20-%20Board%20Approved%20CE%20Providers.pdf

Pennsylvania State Board of Psychology. (2022). *Continuing education information*. https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Psychology/Documents/Applications%20and%20Forms/Non-Application%20Documents/PsychM%20-%20Continuing%20Education%20Information.pdf

FOCUS OF THE YEAR
(CONTINUED FROM PAGE 2)

other behavioral health professionals who are not yet members. To accomplish this, at the convention, every attendee received business cards with imbedded QR codes that facilitate joining PPA with a simple scan using a smartphone. Those who attended my speech raised their hand and took an oath to minimally enroll one new member into PPA membership. I have been talking to members, talking to students, and traveling to colleges to have all I encounter take the same pledge. For those more ambitious, there will be a prize and a magazine article for the person who recruits the most psychologists. If you do not have a QR code, please use www.papsy.org/JoinPPA. Happy hunting!

the bill box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists
AS OF AUGUST 2023

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
SB 59	Providing for the establishment and funding of a center to conduct research on gun violence in this Commonwealth.	Senator Hughes	Support	Referred to State Government 1/19/2023		
SB 119	Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," in public assistance, providing for behavioral health and physical health services integration.	Senator Phillips Hill	Support	Referred to Health and Human Services 1/18/2023		
SB 178	Amending the act of July 19, 1979 (P.L.130, No.48), entitled "An act relating to health care; prescribing the powers and duties of the Department of Health; establishing and providing the powers and duties of the State Health Coordinating Council, health systems agencies and Health Care Policy Board in the Department of Health, and State Health Facility Hearing Board in the Department of Justice; providing for certification of need of health care providers and prescribing penalties," in general provisions, repeals and effective date, providing for acute care mental health bed registry and referrals.	Senator Barlotta	Support	Referred to Health and Human Services 1/19/2023		
SB 276	An Act amending the act of July 9, 1976 (P.L.817, No.143), known as the Mental Health Procedures Act, in general provisions, providing for duty to warn.	Senator Langerholc	Still reviewing bill language	Referred to Health and Human Services 1/31/2023		
SB 445	An Act amending the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, providing for Collaborative Care Model and Primary Care Behavioral Health Model Implementation Program; and making an appropriation.	Senator Farry	Support	Referred to Health and Human Services 3/14/2023		
SB 605	An Act amending the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, in emergency COVID-19 response, providing for adult mental health program funding; and making appropriations.	Senator Collett	Support	Referred to Heath and Human Services 4/19/2023		
SB 739	An Act relating to telemedicine; authorizing the regulation of telemedicine by professional licensing boards; and providing for insurance coverage of telemedicine.	Senator Vogel	Support	First consideration 6/27/2023		
HB 341	An Act amending the act of March 10, 1949 (P.L.30, No.14), known as the Public School Code of 1949, in intermediate units, repealing provisions relating to psychological services; in professional employees, further providing for definitions and providing for school social workers; and, in school health services, further providing for health services and providing for school counselors, school psychologists, school social workers and school nurses.	Rep. D. Miller	Support		Referred to Education Committee 3/13/2023	
HB 1000	An Act amending the act of March 23, 1972 (P.L.136, No.52), known as the Professional Psychologists Practice Act, further providing for definitions; and providing for prescription certificate, for prescribing practices.	Rep. Frankel	Support		Referred to Professional Licensure Committee 7/23/2023	

Bill No.	Brief Description	Introduced By	PPA Position	Movement in Senate	Movement in House	Governor's Action
HB 849	An Act amending the act of April 9, 1929 (P.L.343, No.176), known as The Fiscal Code, in emergency COVID-19 response, providing for adult mental health program funding; and making appropriations.	Rep. Schlossberg	Support	Referred to Health and Human Services	Passed House 173-30 6/14/2023	
HB 575	An Act prohibiting mental health professionals from engaging in conversion therapy with an individual under 18 years of age.	Rep. Benham	Support		Referred to Health 3/20/2023	

CLASSIFIEDS

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Special Section:

The New Drugs

INTRODUCTION TO THE SPECIAL SECTION: The New Drugs

HELENA TULEYA-PAYNE, DEd

When we put out a call for articles about drugs and supplements, we received submissions about therapeutics that are relatively new in augmenting mental health.

Dr. Sam Knapp explores the role of ketamine in reduction of suicidal thoughts and provides cautions for prescribers and their clients. Dr. Warner describes the psychoactive impact of marijuana on the endocannabinoid system, a system that works to maintain homeostasis in our bodies. Dr. Shirley Woika addresses the conditions under which medical marijuana may be administered in the schools. The intriguing contributions of psychedelics in improving mental health are addressed by Mr. James Long and Dr. Rachel Hull. Dr. Jeanne Slattery reacts to a book written by Michael Pollen who describes his experience in using psychedelics. Drs. Anya Geneser-DeRosa, Sean Healy, and Judy Radicio explore ways to respond to questions their clients pose about medication. The discussion of medications and supplements brings to mind: Who is the prescriber? Drs. Krista Boyer and Ms. Katlyn Salva provide an interview with a prescribing psychologist, Dr. Derek Phillips.

INTRODUCTION TO THE ENDOCANNABINOID SYSTEM

DAN WARNER, PhD

This article provides a quick introduction to the network of receptors, neurotransmitters, and enzymes that are the sites of cannabis's (also known as marijuana) psychoactive and medicinal impact. This network is called the endocannabinoid system (ECS). While there is much still being discovered about the ECS, it is commonly understood to be a part of the body's homeostasis mechanism. This system often is triggered by stimulation and responds quickly to calm things back down.

There are two receptors of interest in the ECS: CB1 receptors and CB2. The CB1 receptors are primarily found in the central nervous system (i.e., the brain and spinal cord). The CB2 receptors are found in many peripheral areas of the nervous system, as well as throughout the body (e.g., skin, spleen, white blood cells, endocrine and reproductive systems, and the gastrointestinal and urinary systems). These receptors are typically stimulated by chemicals from inside the body (i.e., endogenous) called endocannabinoids. Most notable is anandamide (named after the Sanskrit word for joy or delight), which has an unusual retroactive motion through the nervous system. This is demonstrated in the accompanying diagram, which shows AEA (anandamide) emerging from the post-synaptic neuron because of the stimulation of neurotransmitters issued from a pre-synaptic neuron. When it emerges, it goes back to the stimulating neuron and couples with its CB1 receptors to slow its firing. As such, the ECS responds to stimulation by slowing it down and bringing systems back to more restful states.

This retrograde process runs through many brain regions, having many effects we are familiar with. For example, anandamides are part of the "runners high," which is not just a release of endorphins, but also of endocannabinoids that are trying to calm an overly exerted body. They are also released as a part of response to extreme fear, calming an activated amygdala during profound stress responses.

Marijuana contains a phytocannabinoid, which means it is a chemical that comes from plants but still impacts the ECS. The phytocannabinoid delta-9 tetrahydrocannabinol (THC), is the one most typically ingested for intoxication and medicine. THC impacts those same receptors much more powerfully than the endogenous endocannabinoids since it binds to the CB1 receptor longer than AEA does.

It is important to note that THC binds to ECS receptors more than endocannabinoids, but still at a level considered "partial." There are products called synthetic marijuana on the black market, which can go by the names of Spice and K-2. These products are full agonists on the ECS system and are dangerously stimulating. They cause rapid heart rate, vomiting, agitation, confusion, and hallucinations. Reactions can even result in death. Except in rare situations of extreme abuse (or large consumption by young children), these results are not typically possible with THC.

As mentioned, these CB1 receptors are plentiful in the brain. We can understand some of marijuana's behavioral effects by noting what it does in the brain. Its slowing effect on the basal ganglia and cerebellum is responsible for how marijuana consumption slows certain motor behaviors and can negatively impact balance. It is also why marijuana is used to calm pathologies of motor behavior such as Parkinsonism (videos on YouTube of cannabis' effects on Parkinsonism are very powerful; see Ride With Larry, 2016).

CB1 receptors are also plentiful in the hippocampus, a brain region involved in memory formation and spatial reasoning. The impacts of cannabis use here are not yet fully understood. There is research that clearly shows that marijuana use reduces blood flow to this area and generally disrupts memory formation. Interestingly, however, long-term use of marijuana does not correlate with atrophy of hippocampal volume or performance but with its development and growth. Further, it seems to promote novel learning and unique problem solving (Haghparast et al, 2023), even though some memory formation is negatively impacted.

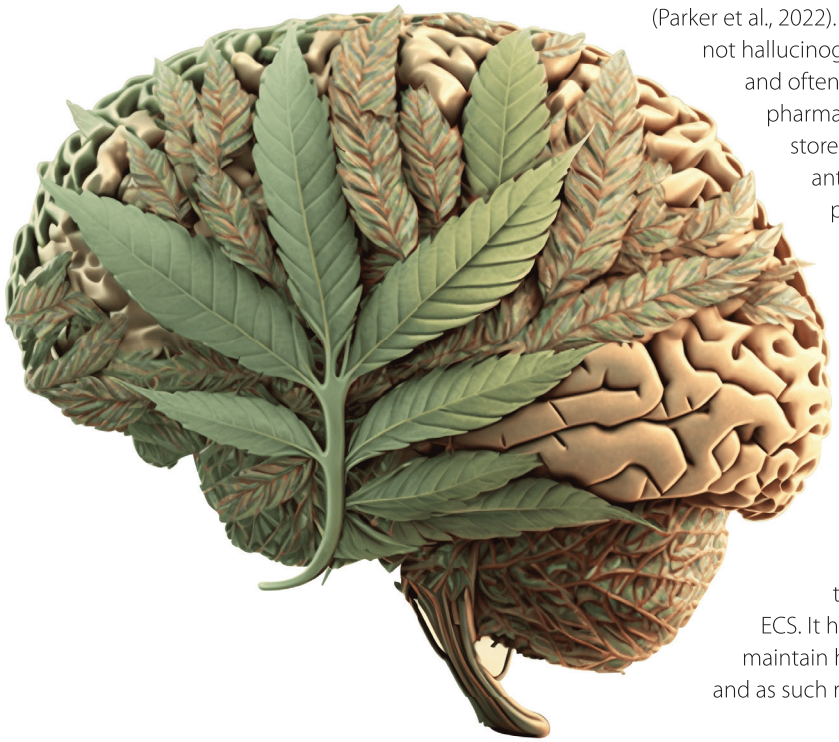
It is important to note that marijuana's impact on anxiety can be quite varied because anxiety itself is quite varied. There is certainly an impact on amygdala function through THC consumption, which appears to be responsible for its positive anxiety-reducing effect. However, it is also

known to kick off anxiety and paranoia. The research on marijuana's effects on posttraumatic stress disorder are mixed (see Rehman et al., 2021). Further, research on marijuana's impact on psychosis is varied, with very credible research showing that CB1 stimulation can trigger psychotic episodes (Hjorthoj, 2021), while a growing body of research showing that CB2 receptor stimulation can help people with psychosis (Batalla et al., 2019).

And we would be remiss without discussing THC's impact on the brain's "pleasure center," or nucleus accumbens. CB1 receptors stimulate this area of the brain, providing positive reinforcement for anything that stimulates them. This is behind the pleasurable part of cannabis consumption, and what also makes its use rife for dependence.

Although it is not as addictive as substances like nicotine or opioids, cannabis use still results in dependence in about 10% of users (National Institute on Drug Abuse, 2021). And the impact is worse on children and adolescents. A recent study called the TennCann study showed that teens using marijuana at the same amount as control adults are more likely to develop dependence on marijuana and have higher risks for psychosis and other health problems (Lawn, 2022). There has been research showing decreased motivation for people who consume a lot of marijuana, especially teens.

Before ending, it is important to turn to a discussion of the CB2 receptors, which do not bind with THC very much, but do bind strongly to cannabidiol, or CBD. CBD is also a phytocannabinoid found in marijuana plants. It is often referred to as the "other" active compound in marijuana. CBD does not interact with the CB1 receptors in the central nervous system. So, it doesn't stimulate the pleasure center, and it doesn't result in the major cognitive impacts associated with THC. Instead, CBD has an impact on the more peripherally located CB2 receptors. CBD has received a lot of attention recently since high doses of it have been shown to increase seizure thresholds, reduce anxiety, and help with pain mitigation through its direct impact on the TRPV1 pain receptors (Parker et al., 2022). Since CBD is not hallucinogenic, it is legal and often available at pharmacies or specialty stores. CBD also has anti-inflammatory properties when placed directly on the skin in an ointment form; it is therapeutic for gout and skin inflammation.



In conclusion, cannabis interacts with the body's natural ECS. It helps the body maintain homeostasis, and as such relaxes certain systems. It is for these reasons it is used to treat problems of overexcitation such as pain and anxiety. It can cause dependence since it stimulates the brain's pleasure center. Cannabis carries side effects and risks, and this should be considered by people as they navigate their health space.

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"SHOULD I BE TAKING THIS MEDICATION/ SUPPLEMENT?"

ANYA GENIESER-DEROSA, PsyD; SEAN HEALEY, PsyD; JULIE RADICO, PsyD, ABPP

As we consider the ever-growing substances individuals use, it is important to reflect on how psychologists can navigate discussing the topic. Discussion of medication may result in anxiety, avoidance behavior, or risky overconfidence in psychologists. We will discuss how to respond when asked by a client/patient if they should start, keep, or stop taking a medication.

CASE EXAMPLE

An individual you are working with in a professional capacity says: "I'm really disappointed that my medications aren't working. My friend is taking Lexapro, too, and she says she doesn't worry about a thing anymore. She feels great. I still get anxious about [x, y, & z], things still bother me. I think I'm going to stop taking my meds, because, really, what's the point?"

WHAT MIGHT YOU SAY IN THE MOMENT?

The following are some ideas of how you may respond with empathy, while maintaining professional boundaries and practicing within the scope of your license.

1. "You're wondering if taking this medication is helpful."
2. "It sounds like you were hoping for the medication to make it so you 'don't worry about a thing.'"
3. "As a psychologist, I do not prescribe medication and therefore, it would be out of my scope to give you a direct recommendation about the Lexapro, though I am happy to help you think about this and consider possible next steps."
4. "Could you share your understanding of what your prescribing clinician said you could expect from taking Lexapro? Benefits? Side effects? Timeframe it would take to start working? The reason for your current dosage?"
5. "Would you be willing for me to reach out to your prescribing clinician related to your concerns?"
6. "Let's draft the message together to make sure I capture it well."

THE THOUGHT BEHIND YOUR TESPONSE (BIOPSYCHOSOCIAL MODEL AND ETHICS)

As psychologists we frequently encounter clients' questions about medication. Typically, these questions may be whether we as psychologists believe that said client should begin, change, or stop a medication. Might certain symptoms or current concerns be due to said medication? And finally, clients may ask us general questions about the side effects of medication. Our response to such queries should involve ethical considerations and how we understand this new and current concern within the client's broader case conceptualization.

The APA Code of Ethics (American Psychological Association, 2017) provides guidance on such questions and in Pennsylvania we are legally obligated to practice psychology under this code. Central to our approach is understanding Section 2.01 Boundaries of Competence. Psychologists have varying levels of education in psychopharmacology. Some have not had any formal graduate or postgraduate training in psychopharmacology, while some may have completed some training through their graduate program or while earning continuing education (CE) credits. Additionally, there are Master of Science in Clinical Psychopharmacology (MSCP) degrees in some states as psychologists pursue licenses to prescribe. Regardless of the level of training or lack thereof, such client questions about medication should always bring to our mind the question of professional competence.

It is beyond the scope of this article to develop a comprehensive ethical framework to understand how we should approach such questions. Nevertheless, we believe that the aforementioned hypothetical responses are in keeping with a fundamental sensitivity to the APA Code of Ethics. Congruent with the General Principles of the APA Code of Ethics, the above responses reflect keen awareness of:

Principle A: Beneficence and Nonmaleficence
- "To resolve these conflicts in a responsible fashion that avoids or minimizes harm."

Principle B: Fidelity and Responsibility
- "Psychologists consult with, refer to, or cooperate with other professionals and institutions to the extent needed to serve the best interests of those with whom they work."

Principle D: Justice
- "The boundaries of their competence, and the limitations of their expertise."

Principle E: Respect for People's Rights and Dignity
- "Self-determination."

The treating psychologist's response to client questions about medication should also be considered within the overall case conceptualization and clinician's theoretical orientation and approach. Biopsychosocial theory (Borrell-Carrió et al., 2004) provides one such useful heuristic. Medication is a biological intervention, and it seems that the client's expectation was that this level of intervention would suffice to significantly decrease and even eliminate anxiety generally and worry specifically. The client's "disappointment" with the medication not meeting their expectations as well as the ongoing anxiety and the emotionally avoidant and maladaptive coping of surrendering can be understood as providing the psychologist with an opportunity to promote more adaptive coping, emotional awareness, and growth. The psychologist can collaboratively explore the understanding (and/or the lack thereof) of how environmental factors and the cognitive, affective, and behavioral bases of behavior intersect and influence overall functioning.

The hypothetical responses demonstrate the psychologist's care and concern and give the patient an important role in having these questions answered by a qualified professional. These hypothetical responses also empower the patient and encourage more adaptive options including, but not limited to, promoting awareness of stressors, locus of control (internal/external), beliefs, attitudes, emotional experience, self-efficacy, coping, and problem-solving skills and/or deficits. Dependent upon the client's response(s) and the clinician's orientation and approach, questions about medication can lead to the facilitation of enhanced insight, emotional intelligence, distress tolerance, self-regulation, acceptance, adaptive coping, action or positive change, and much more.

REACHING OUT/CONSULTING WITH MEDICAL CLINICIANS

Teaching clients the skills necessary to advocate for themselves to communicate their concerns is an important life skill that can benefit them long after psychotherapy ends.

In the case of assisting clients with resolving medication-related questions, it can be helpful to take a "both-and" approach. In addition to developing the client's capacity for self-advocacy, reaching out to the prescriber to apprise them of the situation and collaborate in the patient's care can improve patient care and treatment outcomes (McDaniel et al., 2014).

Before reaching out to the prescriber, obtain the client's written consent with a signed release of information, as well as their assent, discussing and carefully identifying the client's questions and concerns, as well as any information they specifically do not want shared with the prescriber. If the information they wish to

withhold could be important to treatment (i.e., history of substance use), candidly express your concerns and discuss the potential benefits and drawbacks of disclosure, ultimately respecting the client's autonomy and confidentiality, allowing them to make the final decision on what is to be shared.

For the most effective and efficient consultation with a prescriber, spend a few moments organizing the information you would like to convey. Though time pressure in health care can be intense, prescribers are often happy to collaborate, viewing mental health clinicians as consultants integral to optimizing care (Miller-Matero et al., 2016). Keeping this in mind, be ready to:

- Briefly introduce yourself as a licensed professional, including your degree, the setting you work in (e.g., inpatient, outpatient), how you work (e.g., brief psychotherapy, in-depth trauma work), and your role with the client (e.g., individual psychotherapy, length of time working with patient/frequency of sessions).
- Indicate the specific reason for your call (e.g., client perceives medications as not working, is not taking medications, is ambivalent about taking medications).
- Describe the client's reported degree of adherence to medications/ medication-taking patterns as well as their expressed feelings, beliefs, and opinions about medications (e.g., are addicting, will change their personality, are a sign of weakness).
- Succinctly provide the client's diagnosis, symptoms, treatment plan, and prognosis.
- Provide a bullet-point summary of the client's progress in psychotherapy to date (e.g., progress evidenced by assessment measures, follow through or lack thereof on therapeutic homework assignments).
- Ask the prescriber to clarify any questions or concerns you may have about the client or the client's health status that may be relevant to psychotherapy treatment (e.g., Does the patient have a history of substance use? Are there any medical issues, or any other medications or supplements they are taking, that might be relevant to their psychotherapy treatment?).
- Specifically provide the best way to reach you, if possible, offering your mobile phone number and specific dates/times you are available to connect (Fredheim et al., 2011).

Navigating client questions about medications can be challenging; they can provide opportunities for clients to develop new skills, and for clinicians to collaborate and improve quality of care/treatment outcomes. Additional recommendations on how to successfully collaborate with physicians can be found in the following APA materials: https://www.apaservices.org/practice/business/management/tips/collaboration and https://www.apa.org/news/press/releases/2014/05/primary-health-care.

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KETAMINE AS A TREATMENT FOR SUICIDAL BEHAVIOR:
Miracle or Mirage?

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Researchers have long searched for a medication that could reduce suicidal behaviors. Recent reports suggest that subanesthetic doses of ketamine may be a breakthrough in the pharmacological treatment of suicidal behaviors, but a more thorough review of the evidence suggests the need for caution.

Thus far, medications have had a limited impact on suicidal thoughts and attempts. The evidence for effectiveness is strongest for the use of clozapine for patients with psychotic disorders, and the evidence is mixed for the use of lithium for patients with bipolar disorders. Nonetheless, even when effective, these medications could take weeks before they begin to reduce suicidal thoughts, and both can have side effects that limit their acceptability to patients.

Antidepressants also have a mixed record when it comes to reducing suicidal thoughts. Many patients experience a reduction in suicidal behavior after being on antidepressant medication for several weeks. Nonetheless, about 30% of patients fail to respond to antidepressants even after trials with two different medications. Also, antidepressants alone, without psychotherapy or other psychosocial

interventions, are seldom the optimal intervention for patients with suicidal thoughts. "Pills cannot be a caring significant other . . . , help your social and mental isolation, or repair a history of negative interaction and interpersonal trauma" (Maris, 2019, p. 411). Of course, psychologists should always refer patients for medications when it is clinically indicated to do so; they simply should be realistic about the impact of medications on suicidal thoughts and behaviors.

CAN KETAMINE REDUCE SUICIDAL THOUGHTS?

Recent research suggests that ketamine may rapidly reduce suicidal thoughts. Ketamine has been used as a general anesthetic for many years, and recent trials have been conducted on its effect on mental health symptoms, including suicidal ideation. Even though the biochemical mechanisms by which it influences suicidal thoughts are not known, subanesthetic doses have been reported to reduce suicidal thoughts within hours instead of days or weeks. A safe medication that could reliably and rapidly reduce suicidal ideation could revolutionize the treatment of suicidal patients.

The reductions in suicidal thoughts from one infusion typically lasted 3 to 7 days, although reductions of longer durations have also been reported (Witt et al., 2020). Patients who received multiple infusions have reported more sustained improvements. Most of the studies have been done with the intravenous (IV) use of ketamine, delivered in a hospital, and taking 30 to 45 minutes with an additional post-infusion observational period (Witt et al., 2020), but it has also been used in an outpatient clinic with a nurse and a physician present (Kang et al., 2021). Either way, it entails a substantial cost and time to administer. Oral or nasal applications have also been studied, although early reports suggest these application modes are less effective than IV applications.

CAVEATS ABOUT KETAMINE TREATMENTS

However, evidence suggests that the high expectations for ketamine need to be tempered. It is true that studies have found that patients who received ketamine reported fewer suicidal thoughts compared to patients who received a placebo. Nonetheless, these studies often have small sample sizes, lack a long-term follow-up, and typically exclude patients with the most severe suicidal thoughts or the highest risk for suicide; thus, evidence is lacking on its effectiveness with the patients who need it the most. Also, dropout rates are high. For example, Kang et al. (2021) found that about one-third of the participants dropped out of treatment, mostly because of a failure to get the desired results. When one combines dropout rates with the number of partial responders, then it appears that only about 50% of the original participants derived clinically optimal benefits from the ketamine infusion (Kang et al., 2021).

Studies have focused on self-reported suicidal ideation, and data on suicide attempts is scarce. A review found that participants in ketamine treatment conditions attempted suicide less often than those in control conditions, although the numbers involved were small (Siegel et al. 2021). These and other methodological issues led Hochschild et al. (2021) to conclude that, although the research on ketamine is promising, "there is currently no rigorous evidence regarding ketamine's effect on suicidal behavior" (p. 6).

The studies of ketamine have not yet adequately addressed several other issues. Although most studies with ketamine have reported few onerous side effects in the short term, some reports of addiction and withdrawal have been reported among long-term users of ketamine, further warranting caution in how it is used (e.g., Roxas et al., 2021). Also, much is not known about ketamine, including the optimal dose, the optimal mode of administration (infusion, nasal, or oral), how to combine it with other treatments, or how comorbidities may influence its effectiveness.

CONCLUSIONS

Despite these caveats, the Veterans Affairs/Department of Defense (VA/DoD) guidelines recommended the use of ketamine "as an adjunctive treatment for short-term reduction in suicidal thoughts" (Department of Veterans Affairs, 2019, p. 19), although it acknowledged that the empirical strength of this recommendation is weak. I feel more conservative than the VA/DoD. Given the current uncertainties concerning ketamine, I would be reluctant to recommend it as a front-line treatment for suicidal patients. Nonetheless, I would recommend it for suicidal patients with treatment-resistant depression if these patients have been adequately informed of its evidence and limitations and if it is combined with other interventions known to reduce suicidal behavior.

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THE DOORS OF PERCEPTION:
Implications of Contemporary Psychedelic Research

JAMES LONG, BA; RACHEL HULL, PsyD

Interest in the use of psychedelic compounds in therapeutic settings has increased dramatically (Perkins et al., 2021; Wheeler et al., 2020). The enthusiasm highlights the field's growing interest in more "natural" alternatives to conventional pharmaceutical therapeutics (Lowe et al., 2022). The recent surge of research seems apt given many of the frankly unprecedented outcomes reported in clinical studies and qualitative data (Griffiths et al., 2016), often in cases or circumstances traditionally understood as treatment resistant or highly challenging. While overall their therapeutic application is still in the early stages of scientific vetting, it is understandable that psychologists, researchers, and patients would be keen about the potential benefits. Medications often take weeks to begin showing effects, leading to higher drop-out rates and patient frustration. Finding the most effective medication and dosage can take months or years in some cases, forcing patients to grapple with side effects and symptoms along the way. Some patients are hesitant to begin a standard medication regimen. The promise of another physiological approach is certainly worthy of broad and focused interest.

While the possibility of alternatives to standard pharmaceuticals in therapeutic settings garners significant attention, there are deeper implications for the field of psychology within much of the extant research. For example, Griffiths and colleagues (2016) administered two doses of the psychedelic psilocybin to 51 cancer patients with life-threatening diagnoses and symptoms of either depression, anxiety, or both (one low placebo-like dose and one higher dose administered 5 weeks apart). Patients reported improvements in attitudes about life/self, mood, relationships, and spirituality following the higher dose, with more than 80% endorsing moderately or greater increased well-being/life satisfaction. After 5 weeks, 92% of participants who received the higher dosage showed clinically significant responses on the measurement battery. At 6 months, 79% continued to show clinically significant responses. Similar patterns were seen among all batteries and were commensurate with clinical observation and reports gathered from close others in the patients' lives. These are staggering outcomes for any chemical intervention after only a single dose. Perhaps the most important finding of the study was that overall outcome was mediated by the presence of mystical-type experience within the participants who received the higher dosage of psilocybin.

While there are many current theories as to how or why psychiatric medications show effects, most rely on biological alterations of neurotransmitters. One theory accounting for the effects, as well as the time delay of antidepressants, is that the alterations in brain chemistry allow for adult neurogenesis in areas such as the hippocampus; the 4- to 6-week period reflecting the time it takes for sufficient neuronal growth to occur (Anacker et al., 2011; Malykhin et al., 2010; Planchez et al., 2019). Other evidence implicates effects at the genetic level, in which mRNA mediates alterations leading to mood and behavior outcomes (Baudry et al. 2010). Considering the robust evidence for large-scale alterations in gross brain matter in patients with various diagnoses, such as atrophy in the hippocampus in those with major depressive disorder (Videbech & Ravnkilde, 2004), such theories seem likely. Given this, they still rest on an implicit assumption of gradual change at the biological level as their means of effecting change. No competent psychiatrist would expect meaningful and prolonged improvement from a single dose of a selective serotonin reuptake inhibitor, for example, and yet that is precisely what has been identified in some of the contemporary psychedelic research.

The results from Griffiths et al. (2016) have been supported by numerous other studies. Barrett et al. (2020) showed reduction in negative affect and amygdala response to facial affect stimuli and increases in positive affect and dorsolateral prefrontal and medial orbitofrontal cortex responses to emotionally conflicting stimuli 1 week after psilocybin administration. At 1-month follow-ups, positive effects remained elevated, and participants' trait anxiety had decreased. Murphy et al. (2022) found

that outcomes in psilocybin-assisted therapy loaded partially onto mystical experience but were also heavily reliant on the presence of emotional breakthrough experiences in patients preceding such experiences, interpreted as indicative of the therapeutic alliance within the process. Trait neuroticism was shown to be associated with "challenging" experiences during psilocybin use, indicating that resistance to the experience played a strong role in outcomes (Barrett et al., 2017). Finally, in a qualitative study of psilocybin use in veterans with symptoms of trauma, all participants reported immediate and long-lasting improvements after use; however, in all cases, they attributed the improvement to alterations in their perspectives achieved during the experience and in subsequent weeks (Smith et al., 2022).

The precise mechanisms and circumstances under which individuals do and do not experience significant changes in mood and behavior after psychedelic experiences is unknown, and continued investigation is important moving forward; nonetheless, the immediate and long-lasting changes seen across reports and modalities calls into question explanations that rely on a bottom-up and strictly biological causal mechanism. Instead, current evidence seems to strongly imply that a powerful enough shift in one's cognitive frame can in-and-of-itself alter previously intractable mood and behavior patterns, as well as potently alter the patterns and operations of biological structures within the brain (e.g., the amygdala). Regardless of the immediate benefits such substances may have for millions of individuals suffering from various psychological difficulties, psychedelics pose compelling questions about our contemporary understanding of psychological etiology, nosology, mental hierarchy, and how behaviors, perspectives, and meaning structures are maintained and developed within the psyche.

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Q&A: The Life of a Prescribing Psychologist

KRISTA BOYER, PsyD, MBA, LPC; DEREK PHILLIPS, PsyD, MSCP, ABMP; KATELYN SALVA

Do you have an interest in becoming a prescribing psychologist? The following Q&A was conducted with Dr. Derek Phillips, a prescribing psychologist based in Illinois and the Executive Director of the Master of Science in Clinical Psychopharmacology (MSCP) program at Fairleigh Dickinson University (FDU). Dr. Krista Boyer, the interviewer, is currently attending FDU to earn her MSCP with the hopes of becoming a prescribing psychologist in Pennsylvania once the legislation passes. With the help of undergraduate student, Katelyn Salva, the following interview was conducted to delve into the day-to-day clinical activities of a prescribing psychologist.

KRISTA: Tell us a little bit about yourself and your professional roles.

DEREK: I work full-time as a clinical neuropsychologist and prescribing psychologist in the

Department of Neurology at Sarah Bush Lincoln Health Center, a public, nonprofit, regional hospital system that serves several semi-rural counties in east central Illinois. I have been a licensed clinical psychologist since 2016 and a licensed prescribing psychologist since 2021. In fact, I was the 12th licensed prescribing psychologist in Illinois; there are now 18! I also work part-time (and remotely) as Executive Director of the MSCP program within the School of Psychology and Counseling at Fairleigh Dickinson University, based in Teaneck, New Jersey. I have been in this role since 2020. FDU's MSCP program is one of only five APA-designated training programs in clinical psychopharmacology and was the first to earn APA designation in 2010 when designation began.

KRISTA: Why did you decide to become a prescribing psychologist?

DEREK: I first heard about the prescriptive authority for psychologists (RxP) movement and prescribing psychologists in my first year of graduate school at Adler University (formerly Adler School of Professional Psychology) in Chicago. In fact, first-year PsyD students were required to complete a "Community Service Practicum" as a way to give back to the community and I was lucky enough to be placed at the Illinois Psychological Association (IPA) headquarters in downtown Chicago. At IPA, the project I worked on for 6 months was grassroots advocacy for RxP in Illinois, which happened to become law 4 years later. Being part of the movement at that time made it easy to decide that I wanted to become a prescribing psychologist.

KATELYN: Where did you receive your psychopharmacology training? Do you feel you were adequately prepared for prescribing?

DEREK: I obtained my MS in clinical psychopharmacology (MSCP) at Fairleigh Dickinson University in 2019 and then completed my prescribing psychology fellowship at Sarah Bush Lincoln Health Center from 2020–2021. In addition to the MSCP, I completed (per Illinois requirements) several biomedical courses, including medical terminology, general biology, general chemistry, microbiology, human anatomy, human physiology, and anatomy and physiology. For my prescribing psychology fellowship, also per Illinois' requirements, I completed rotations in family medicine, internal medicine, psychiatry, pediatrics, geriatrics, emergency medicine, surgery, obstetrics/gynecology, and neurology, totaling 1,620 hours over 18 months. Because of this extensive education and training in clinical psychopharmacology, I absolutely felt well-prepared for prescribing.

KRISTA: What do your day-to-day clinical activities entail?

DEREK: As both a clinical neuropsychologist and prescribing psychologist, my clinical activities include several different things. Some examples include initial evaluations for new patients, administering neuropsychological tests, interpreting neuropsychological tests and writing reports, delivering neuropsychological testing results to patients, medication management (including medication reconciliation,

interaction checks, sending new prescriptions or refills to pharmacies), ordering laboratory blood work or imaging tests, consulting with other providers regarding psychotropic medications, and reviewing my orders and cases with my collaborating physician.

KATELYN: How have your interactions with clients changed since becoming a prescribing psychologist?

DEREK: My interactions with patients are enriched since I better understand the biological components of the biopsychosocial approach. For example, I feel equipped to listen to a patient's reported physical problems and then counsel them on what medical interventions might be necessary, even if I am not who will be delivering the intervention. I also am much more qualified and comfortable in determining if a particular set of symptoms has a medical component that needs to be assessed and possibly treated before psychosocial interventions are appropriate. Overall, the care I provide is less fragmented since I can provide psychotherapy, neuropsychological testing, medication management, consultation, and so on.

KRISTA: How do the activities of a prescribing psychologist integrate into your clinical activities?

DEREK: The activities of a prescribing psychologist have seamlessly integrated into my existing practice. As experts in diagnosis of mental illness and providing psychotherapy, it is a natural extension to also treat psychiatric conditions with medication, if indicated. In fact, it makes more sense to patients too when psychologists, who are providing other psychological services, are able to prescribe medication.

KATELYN: Can you describe the balance between prescribing work and clinical work throughout your week?

DEREK: Because my employer wants to ensure that neuropsychology services continue to be widely available to my community through my services, I spend a relatively small amount of my clinical time (about 15%) in medication management appointments. However, I use my clinical psychopharmacology and medical knowledge with every patient regardless of the specific reason they have been referred.

KATELYN: What new ethical issues have you faced since becoming a prescribing psychologist?

DEREK: The primary ethical issue that I have faced since becoming a prescribing psychologist is determining where mental health ends and physical health begins. We know that our health is not actually separated in this way, despite the world's best attempts to keep them siloed. If a patient of mine has obesity and would like to be prescribed weight loss medication, is that permissible for a prescribing psychologist? Does obesity not affect mental health? Of course, it does; however, I do not consider obesity medicine to be within my scope of practice even if weight and mental health are intricately linked. What if my patient has dementia and wants to be treated with medication to slow memory loss? If I prescribe that type of medication, am I now practicing neurology? To me, the answer to this question is less clear, but still perhaps an ethical consideration for a prescribing psychologist.

SCHOOL PSYCHOLOGISTS' ARE HIGHLY QUALIFIED TO BE SCHOOL BOARD DIRECTORS: This Will Ultimately Benefit Students, Teachers, and Community Stakeholders

RICHARD E. HALL, PhD

In this article I want to strongly encourage my fellow school psychologists to consider using their talents to expand their advocacy for students by not only moving into administrative roles such as school principal or school superintendent for which we are well suited and have been quite successful, but also seeking positions such as a school board director. In this position, school psychologists can use their knowledge and skills to exert significant and positive influence on important school district decisions such as the choice of academic curricula, school discipline procedures, teacher recruitment and retention, and much more. I would like to illustrate just how well prepared school psychologists are for this role given our knowledge, experience, and scientific training by comparing the skills, knowledge, and attributes of effective school psychologists to the skills, knowledge, and attributes of effective school board directors.

Many years ago, I wrote a paper (my doctoral dissertation in fact) describing a somewhat rough method for predicting the likelihood of a person being successful in a new, challenging, and/or unfamiliar environment (Hall, 1995). In the paper I described what is known as "template matching," where the demands and expectations of a future environment or future role are delineated by developing a template of the characteristics and attributes of those who have been successful in those environments and then comparing a similarly developed template for individuals who are considering the new role. In template matching, the closer the match between the skills and attributes of successful individuals in a particular role and the skills and attributes of individuals considering this role, the greater likelihood the individuals will be considered successful once in this new position.

Let's first examine what skills and attributes characterize school psychologists who are effective in their work with students, administrators, parents, and teachers. Several characteristics have been consistently identified in the literatures as being commonly associated with successful and effective school psychologists (Thomas & Grimes, 2002; Segal et al., 2021; Rosenfield, 1996; Whiteman et al., 1982). These include the following 10 attributes:

1. Strong interpersonal skills: Effective school psychologists can effectively communicate and build relationships with students, parents, teachers, and other staff members. They are empathetic, approachable, and able to establish trust and rapport.
2. Patience and empathy: Successful school psychologists are patient and understanding when working with students who may be facing academic, social, or emotional challenges. They can empathize with their struggles and provide the necessary support.
3. Effective problem-solving skills: Effective school psychologists have strong analytical and problem-solving abilities to identify and address the needs of students, whether it is academic, behavioral, or emotional.

They can develop appropriate interventions and strategies to help students overcome difficulties.

4. Flexibility and adaptability: Effective school psychologists are adaptable to the unique needs and circumstances of each student. They are open to different approaches and willing to adjust their methods to suit individual situations.
5. Strong assessment and evaluation skills: Effective school psychologists are skilled in conducting comprehensive evaluations to identify learning or behavioral disabilities. They are competent in interpreting assessment results and providing appropriate recommendations and interventions.
6. Continuous learning and professional development: Successful school psychologists are committed to ongoing learning and professional development to stay updated on the latest research, interventions, and best practices.
7. Collaboration and teamwork: Effective school psychologists have excellent collaborative skills, working effectively with others to develop comprehensive plans and interventions for students.
8. Responsive and accessible: Effective school psychologists are easily approachable, actively listening to and addressing the concerns and ideas of various stakeholders, including parents, students, and staff.
9. Ethics and confidentiality: Effective school psychologists adhere to ethical guidelines and maintain confidentiality to create a safe and trusting environment for students, parents, and staff.
10. Commitment to diversity and inclusion.

Now let's look at research-identified characteristics and skills of successful school board directors. The research literature identifies characteristics that are associated with effective school board directors (Asahak et al., 2018). They include the following 10 skills and characteristics:

1. Visionary: They have a clear and forward-thinking vision for the school district, ensuring that their decisions align with the long-term goals and interests of students, families, and the community.
2. Strong communication skills: They can effectively communicate with various stakeholders, such as parents, educators, community members, and other board members, to build consensus, convey district goals, and address concerns.
3. Ethical and transparent: They maintain high ethical standards and bring transparency to their decision-making processes, ensuring accountability to the public and demonstrating honesty in their actions.
4. Collaborative and team-oriented: They work well with other board members, fostering a positive team dynamic and collective decision making. They value different perspectives and are willing to compromise when necessary to achieve the best outcomes for students.
5. Knowledgeable about education policies: They stay informed about educational policies, research, best practices, and local/state regulations to make informed decisions that positively impact student outcomes and address the district's challenges.
6. Advocate for student success: They prioritize student well-being and educational equity, advocating for policies and resources that support all students in achieving their fullest potential.

7. Analytical and problem-solving skills: They can analyze complex educational and financial data, evaluate programs and policies, identify areas for improvement, and make informed decisions that best serve the district's educational mission.
8. Commitment to diversity and inclusion: They champion diversity and inclusivity in all aspects of the district, seeking equitable access to resources, opportunities, and educational experiences for students, regardless of their background.
9. Responsive and accessible: They are easily approachable, actively listening to and addressing the concerns and ideas of various stakeholders, including parents, students, and staff.
10. Continuous learners: They are committed to ongoing professional development, staying up to date with changing educational trends and research, and engaging in relevant training to better understand and address the evolving needs of students and schools.

In the table below, I compare the characteristics of effective school psychologists with those of successful school board directors. If the descriptions are essentially congruent, I noted them as being a "match." If they share some aspects, I noted them as being a "partial match" and give half credit. In my research (Hall, 1995) when there was a 70% to 100% match, the individual was later rated "successful" by others in that setting.

Match Status	Characteristics of Effective School Psychologists	Characteristics of Effective School Board Directors
Match	1. Strong interpersonal skills	1. Strong communication skills
No Match	2. Patience and empathy	2. Visionary
Match	3. Effective problem-solving skills	3. Analytical and problem-solving skills
No Match	4. Assessment and evaluation skills	4. Knowledgeable about education policies
Match	5. Continuous learning and professional development	5. Continuous learners
Match	6. Collaboration and teamwork	6. Collaborative and team-oriented
Match	7. Responsive and accessible	7. Accessible to students, teachers, parents, and administrators
Match	8. Ethics and confidentiality	8. Ethical and transparent
Match	9. Advocates for effective practices	9. Advocate for student success
Match	10. Commitment to diversity and inclusion	10. Commitment to diversity and inclusion
80% Match	An individual with an 80% match is likely to be successful in the new role.	

It is clear from this review of characteristics of effective school psychologists and effective school board directors that there is significant overlap between the characteristics of these two groups such that school psychologists would be ideal candidates for these positions. Additionally, a school psychologist could dramatically extend and expand their positive impact on the students, teachers, and community stakeholders in the district.

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MEDICAL MARIJUANA: Advice for Schools

SHIRLEY A. WOIKA, PhD

There is a good deal of controversy surrounding the use of medical marijuana, especially when it is used with children and teens. Nonetheless, more than half of the country has legalized medical marijuana in some form, including cannabidiol (CBD). CBD is typically administered under the tongue as an oil, and it is not intoxicating.

On April 17, 2016, Pennsylvania's Medical Marijuana Program was signed into law. The program was designed to provide access to medical marijuana for patients "with a serious medical condition through a safe and effective method of delivery that balances patient need for access to the latest treatments with patient care and safety."

The first step to obtaining medical marijuana in PA involves registration. A profile must be created in the medical marijuana registry that requires basic identifying information. Participants must have a PA driver's license or an ID card issued by the PA Department of Transportation. The second step involves having an approved physician certify that the participant has a qualifying medical condition. There are 23 approved medical conditions. Those most likely to be diagnosed in school-age children include anxiety, autism, cancer, epilepsy, inflammatory bowel disease, intractable seizures, neurodegenerative diseases, post-traumatic stress disorder, sickle cell anemia, terminal illness, and Tourette syndrome.

Physicians who recommend medical marijuana must also be registered with the Department of Health. After being certified by an approved physician, participants must return to the medical marijuana registry and complete an application for a medical marijuana card. There is a $50 fee for the card; however, individuals who receive assistance (CHIP, SNAP, WIC, etc.) may be eligible for fee reductions. Once an ID card is secured, medical marijuana can be purchased from a medical marijuana dispensary.

This process is a bit more complicated for minor patients. Minor patients are required to have caregivers pick up medical marijuana at a dispensary on the minor's behalf. Caregivers must be at least 21 years

old and a PA resident with a valid PA driver's license or state-issued ID card. Caregivers must also complete a criminal history background check showing that they have not been convicted of a criminal offense related to the sale or possession of drugs, narcotics, or a controlled substance in the last 5 years. The caregiver must register for a medical marijuana patient and obtain an ID card to pick up medical marijuana at a PA dispensary. Caregivers for minors who are not the patient's parent, legal guardian, or spouse must be designated as a third-party caregiver by the patient, the patient's legal guardian, or the patient's spouse.

The Pennsylvania Department of Health and the Pennsylvania Department of Education support the administration of medical marijuana when a Patient Authorization Letter is provided for a student with a serious medical condition while also maintaining a safe environment for others on school grounds. The Departments of Health and Education have subsequently provided some guidance to schools to assist in developing policies for the administration of medical marijuana on school grounds.

At present, it is recommended that a parent, legal guardian, or caregiver administer medical marijuana to students on school properties; however, the parent/guardian/caregiver must provide a copy of the Patient Authorization Letter to the principal. Additionally, the principal must be given notice by the parent/guardian/caregiver in advance of each administration of medical marijuana to the student. It is recommended that the school principal notify the school nurse in each instance that a student will be administered medical marijuana.

Recommendations also include having parents/guardians/caregivers comply with all existing school protocols specific to visitors to the school during the school day. The parent/guardian/caregiver should bring the medical marijuana to the school and administer it to the student without creating a distraction. Any excess medical marijuana and related materials must be removed from the school premises once the administration is complete. A secure and private location should be provided by the school for administration of medical marijuana to the student. Students should never be in possession of medical marijuana on school property or during any school activities.

According to several news releases, a PA state representative, Democrat Malcolm Kenyatta, is planning to propose legislation that would allow school nurses to administer medical marijuana in the school setting. At present, this medication must be administered by a parent, guardian or caregiver. Thus, if a student needs medical marijuana during the school day, a parent/guardian/caregiver must come to the school to administer it. If such legislation is proposed and adopted, schools would need to respond accordingly. For now, school nurses are not approved to administer medical marijuana in schools.

For additional information about Pennsylvania's medical marijuana program, consult the following website: https://www.pa.gov/guides/pennsylvania-medical-marijuana-program/.

YOUR MIND ON PLANTS? A Book Review

JEANNE M. SLATTERY, PhD

Michael Pollan could sell bottled water to people during a flood or sand in the midst of a dust storm. He is an interesting sort of salesperson, as he often shares his skepticism–and paranoia–but he is clearly enthralled by hallucinogens and other drugs, although wants to use them in the right environment with the right guide. His reactions are contagious. During the section on opium in *This Is Your Mind on Plants* (Pollan, 2021), I was considering planting poppies (and maybe doing more with them), despite largely being a teetotaler.

I started reading *This is Your Mind on Plants* (Pollan, 2021)–and Pollan's (2018) older book, *How to Change Your Mind*–with strongly negative attitudes about hallucinogens. I'd listened to Seasons 1 and 2 of the podcast, *Cover Story* (Wright & Ross, 2021-2022), on the role of hallucinogens in treating people with trauma and unresponsive depression. *Cover Story* was clear that there are a number of poorly trained and unethical practitioners out there who have done the sort of work that makes my skin crawl. For example, they described numerous boundary violations with especially vulnerable people. Some of the people *Cover Story* discussed were independent guides, but others were associated with the MAPS project at Johns Hopkins, which is often touted as the leader in psychedelic research.

Pollan did not report being exploited in his explorations of psychedelics, but he was picky about who served as his guides. As he repeatedly observed, set and setting matter (i.e., how you think about the experience, where and with whom you have it), and he made sure that he had both a good set and setting. That set and setting matter suggests that effects reported are not solely due to the drug. There is at least some placebo effects at play.

For those of you who haven't yet read Pollan (this is my fifth of his books) part of what I enjoy about his books, in addition to his thoughtful writing, is his broad contextualization of his topic. For example, in looking at the role of culture in the drug experience, he concluded, "In the West, our understanding of drugs is organized around ideas of hedonism, the wish for escape, and the desire to dull the senses" (Pollan, 2021, p. 212). And, he challenged that we identify some plants as drugs, while accepting others as medicine, even endorsing their use as everyday pleasures.

SOME CONCERNS

It is difficult to do good research on the efficacy of hallucinogens–either searching for the well or for the dying, addicted, or depressed. Participants in such research are probably unusual, not a random sample from the larger population (remember, set and setting?). In addition, outcome studies are difficult to interpret, as one cannot compare hallucinogens to a placebo, even an active placebo, as it is clear that hallucinogens have an effect on the mind, one that subject, guide, and researcher recognize: One cannot do single, double, triple blinded research with hallucinogens. True believers, like Pollan, do not stop to question the implications of this problem. We know, for example, that placebos are more effective depending on their cost, size, color, side effects, the patient's beliefs, and the doctor's empathy and time with the patient (Marchant, 2015).

And, I wonder whether psilocybin and other hallucinogens can really become wonder drugs for the masses. In the 1950s and 1960s, people were paying $500 a session for hallucinogen-assisted therapy. If the cost of hallucinogens came down (but do we really expect that Pfizer and Lilly will get involved unless they believed they could make a profit?) much of the cost would still be human labor. Would any insurance panel be willing to pay for one or two professional mental health workers to accompany a participant for a five-hour session? Would the guides be poorly trained and paid? Reconsider this given *Cover Story's* (Wright & Ross, 2021-2022) concerns about the ethics of many in the field.

And yet, the worried and wealthy well who read Pollan (2018, 2021) and are looking to expand consciousness will find psilocybin and other hallucinogens tempting. The rest of us will find his writing engaging and thought-provoking.

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INSURANCE COMMITTEE

The PPA Insurance Committee (IC) monitors and addresses a range of issues related to commercial (private) and public (Medicare/Medicaid) payers. Its purpose is to serve as a resource to PPA leadership and membership on insurance matters and the practice of professional psychology in Pennsylvania. The Insurance Committee is currently comprised of 24 members located throughout the state. We meet quarterly to review developments in law, regulations, policies and procedures for governmental entities and commercial providers as well as to discuss emerging trends. Given the number of public and private insurance entities, we divide up the monitoring of the major third-party payors to keep abreast of developments and these are shared at our meetings or through communications among the IC membership as needed. The Insurance Committee is active in seeking to develop new and positive relationships with leaders in the world of insurance, as our committee firmly believes in working collaboratively with public and private insurance carriers to demonstrate the value that professional psychology brings to individual and public health.

The Insurance Committee consults with PPA leadership on general trends and developments and also specific questions or concerns that arise. This has been especially true during the COVID-19 Public Health Emergency, the post-PHE period and the emerging prominence of telehealth practice. The IC has taken the lead in creating and updating a document posted on the PPA website to assist members with frequently asked questions and concerns. For your convenience this document can be found here: https://cdn.ymaws.com/www.papsy.org/resource/resmgr/docs/2023/end_of_public_health_emergen.pdf.

The IC is also active in a number of other ways. We held a Connecting Hour during the PHE to answer questions from PPA members. These will continue to occur as needed. Additionally, the Insurance Committee Members and Chairperson frequently address insurance-related questions posed on the listserv. Finally, depending on the concern, consultation with individual members on insurance-related issues are also conducted.

If you think you might have an interest in joining our committee in our important and crucial work, please don't hesitate to reach out to Sean Healey, Chairperson, at sean.healey.psyd@gmail.com.

Sean Healey, Psy.D
Chairperson, PPA Insurance Committee

What you need to know about license renewal

30 Psychologists in Pennsylvania must earn 30 CE credits per biennium. Biennia run from odd year to odd year. For example, **December 1, 2021 – November 30, 2023**

Credits for psychologists must come from: An APA approved provider/course; an AMA approved provider/course; a provider approved by the State Board of Psychology; an accredited college or university with semester hours, related to the practice of psychology

Webinars: Live vs. Home Study

Live, interactive webinars happen in real time, when the speaker is able to interact with the attendees. Note: this can happen in a pre-recorded webinar *as long as the presenter is available to answer questions in real time* (in the chat or Q&A, for example.)

Pennsylvania Psychology License Renewal Checklist

30 credits required

- No more than 15 credits can be obtained via home study courses or asynchronous webinars
- 3 Ethics - The word "ethics" must be part of the title, or the certificate must state that the credits apply for ethics credits
- 2 credits - Child Abuse Recognition and Reporting - Act 31
- 1 credit - Suicide Prevention



MTSS IN HIGHER EDUCATION

SUSAN EDGAR-SMITH, PhD; REBECCA LAUREN GIDJUNIS, MFA; CATHERINE A. KUNSCH, PhD

The transition from high school to college is simultaneously positive and challenging for many students, especially post-pandemic (Copeland et al., 2021; Mulhern & Steiner, 2022; Reyes-Portillo et al., 2022). They are forming new relationships apart from their families and immersing themselves in new instructional practices and learning expectations that are commonly more demanding than in high school (Holschuh, 2019; Springer et al., 2014).

As in lower education, higher education struggles to keep up with demands for academic, and social-emotional supports (Center for Collegiate Mental Health, 2022; Lipson et al., 2022), and unlike lower education, they are new to tiered support systems. In the PreK–12 environment, a multitiered system of supports (MTSS) is a framework that closely monitors student progress data to proactively maximize student achievement and ensure students' academic, socioemotional, and behavioral well-being. MTSS offers a layered continuum of intervention and is typically composed of three tiers, each offering increasingly more intense support as needed. Student progress and the efficacy of interventions are scrutinized by key stakeholders. For MTSS to succeed, an interdisciplinary team ensures the completion of regular screenings, actively monitors student progress, and offers evidence-based interventions at each tier.

Built upon the framework for high school MTSS practices espoused by Flannery and Sugai (2009) and others (Bradshaw et al. 2015; Flannery et al., 2018; National High School Center, National Center on Response to Intervention, & Center on Instruction, 2010), a collaborative team of faculty and academic support staff at Eastern University created a preliminary MTSS system to address the increased needs of the first-year student population. The first step was to identify which key competencies were presenting as the biggest hurdles to attainment. Student development personnel, academic support staff, faculty members, and student advisors provided input and data. After considerable review, three competency areas were identified: (1) Academic; (2) Conduct; and (3) Social-Emotional, Spiritual, and Diversity, Equity, and Belonging (DEB). Academic areas of struggle included deficiencies in basic skills such as studying, notetaking, time management, work completion, class attendance, and academic integrity. Conduct competency areas of struggle involved campus culture, living in the community, and complying with conduct expectations. In terms of Social-Emotional, Spiritual, and DEB competencies, students struggled with emotional regulation, peer interactions, spiritual formation, cultural awareness, inclusive thinking, and self-efficacy.

Secondly, existing resources across the university in such varied departments as academics, student life, and athletics were identified. From there, supports for each tier and pivot point were articulated: Academic, Conduct, and Social-Emotional. This assessment helped the team to gather data on strengths and gaps, which led to the implementation of solutions. For instance, the summer academic preparation program was expanded to double the number of students served, a one-credit college success course was implemented to help students persist and connect them with ongoing mentoring, and the counseling model was reworked to connect students with external resources so as not to exhaust internal ones.

Not surprisingly, one of the biggest challenges was developing a system that would allow faculty, advisors, student life, and other key personnel to refer struggling students, and then to monitor their use (or non-use) of resources. An extensive shared MTSS flowchart provided tiered support resources for each competency area. Then each competency was subdivided into specific support needs. For instance, academics was divided into (1) Writing concerns, (2) Course Subject concerns, (3) Work Completion concerns, and (4) Attendance concerns. Fortunately, there were long-standing and successful interventions in place to support these areas: Academic Coaching, Writing Specialists, Course Tutors, and Counselors. The only drawback is that they are geared toward Tier 1, with some Tier 2, support. For example, instructors would talk with the student about Academic concerns and then refer them to the support resources listed in the flow chart. The faculty essentially followed their typical routine of referring students for help at a Tier 1 level.

Creating an effective Tier 2 and 3 referral model was more complicated and where most of the innovative work was done. The MTSS team created triggers for referring a student for moderate (Tier 2) or serious (Tier 3) interventions. For instance, if a student was absent from classes for 1 week, they were considered in need of Tier 2 intervention. Their absence was reported to their advisor who then contacted the student to set up a meeting to determine necessary supports. In Tier 3, when a student missed 2 weeks of classes, an instructor notified both the advisor and the Dean of Students who requested a "wellness check" by Student Life personnel. The dean of each college kept a spreadsheet record of all Tier 2 and Tier 3 referrals to monitor students' progress through the system with frequent contact with advisors and instructors to assess student progress.

Each competency area had its own tiered system of support, and by the end of the academic year, there was organized way to refer students for help in notable areas of their lives. But the system needs considerable tweaks. More developmental coursework during the first and second semesters in the areas of writing, reading, and math should be provided. Faculty and staff determined that a revision of classroom and student life conduct manuals was needed to address new concerns that arose during the year (e.g., Academic Honor Code and student use of ChatGPT, marijuana use in residence halls now that it is becoming more accessible, etc.). Work continues on a more automated referral system that will connect students faster to resources. This system will utilize a combination of self-reported and Learning Management System-derived data that MTSS team members can assess and monitor regularly, especially the progress of students needing Tier 2 and 3 supports. With more efficient processes, resources, and professionals in place, the plan is to monitor student retention and academic success to better gauge the impact of the MTSS program. This upcoming academic year, we look forward to providing our students with a better transition from high school to college and beyond.

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PSYCHEDELIC-ASSISTED TREATMENT: More Questions Than Answers

JEANNE M. SLATTERY, PhD; LINDA K. KNAUSS, PhD; DEB KOSSMANN, PsyD; SAM KNAPP, EDD; ASHLEY GREENWELL, PhD

This discussion is part of a series examining clinical dilemmas from an ethical perspective. The five of us differ in our attitudes toward psychedelic-assisted treatments and substance use and enjoy looking at questions from multiple perspectives. Rather than immediately reading our responses, consider carefully working through the vignette first.

A long-term client of Dr. Clean, Lucus Enla Skye, returned to treatment after a several year hiatus. A therapist Mr. Skye saw in the interim had suggested psilocybin-assisted treatment with another "therapist," unlicensed in the United States, who comes here several times a year to facilitate psilocybin-assisted sessions. Mr. Skye began the psilocybin-assisted treatments before returning to Dr. Clean's care and has had five sessions to date. Each session involves a phone meeting before the treatment to set goals for the 5-hour journeying session; the "therapist" is physically present for the journey. There is also a processing session afterward. The "therapist" recommends that people be in their own psychotherapy. Mr. Skye wants to continue psilocybin-assisted treatment, claiming it helps.

Dr. Clean believes that it has been useful, but because this treatment is currently illegal, Mr. Skye won't give Dr. Clean any information about the "therapist." As a result, Dr. Clean is unable to coordinate treatment goals or client care the way he typically would with another treating professional.

What Do We Know?

Many people with psychiatric illnesses are believed to be treatment resistant, perhaps as many as 20–60% of those requesting treatment (Howes et al., 2022). For example, 33% of people diagnosed with major depressive disorder failed to respond to four stratified levels of treatment (Rush et al., 2006). Those requiring higher levels of treatment were more likely to relapse. As a result, practitioners have focused on newer and less researched interventions, including microdoses of psilocybin.

Psilocybin has become popular because it seems to have relatively long-lasting therapeutic effects with infrequent dosing relative to more traditional treatments, such as selective serotonin reuptake inhibitors. Practitioners using psilocybin often pay attention to issues of set and setting, much like in psychotherapy (Ziff et al., 2022), suggesting that psilocybin outcomes are not solely related to the drug's action. Set refers to the client's and therapist's motivating factors, intentions, and expectations, often discussed in detail before a session. Setting refers to the physical, mental, and emotional environment of the patient before and during treatment, which often is more like a New Age meditation room than a doctor's office.

To date, published studies have been few and relatively small, with Irizarry et al. (2022) only identifying 10 studies for their meta-analysis. Initial results have been promising. Participants performed as well on psilocybin as other effective treatments in 9 of the 10 studies discussed. Notably, a trial of two sessions of psilocybin has effects on depression lasting from 4 to 8 weeks, with at least a 50% reduction in symptoms on the GRID-Hamilton Depression Rating Scale (Irizarry et al., 2022). Further research is needed to determine if the effects reported are long lasting, but it appears to be less addictive than alternatives such as ketamine.

Would you like to be involved in future discussions of vignettes? Let us know by emailing jslattery176@gmail.com.

Being competent in our work with such a client would require at least a basic understanding of this research and a willingness to adapt our treatment accordingly (American Psychological Association, 2017).

Whose Treatment Plan Is This?

Mr. Skye is participating in one common strategy for integrating psilocybin with psychotherapy. In a state like Pennsylvania, this treatment plan has several problems, not least of all that psilocybin is illegal here. In this case, Dr. Clean did not feel that psilocybin was part of his treatment plan with Mr. Skye and was uncomfortable about having no communication with the other "therapist." He would not typically recommend psilocybin to a client.

Dr. Clean also had concerns about this intervention given Mr. Skye's history of trauma. He worried that psilocybin would likely loosen Mr. Skye's boundaries and defenses. If Dr. Clean continued to treat Mr. Skye, would this be perceived as giving tacit approval for psilocybin? On the other hand, if Dr. Clean decides not to continue working with him, would this put Mr. Skye at greater risk given the difficulties in finding a new psychotherapist caused by current mental health provider shortages? Could Mr. Skye potentially experience this as abandonment? Dr. Knapp recommended that Dr. Clean should talk to a risk management consultant (such as ones available from some professional liability insurers) and document his rationale for his decisions. In addition, progress should be monitored regularly using a standardized measure of well-being such as a mental status examination or an objective test such as the Treatment Outcome Package (TOP) or Outcome Questionnaire (OQ-45.2).

Questions and More Questions

Although the research looks promising, there are still significant gaps in the literature. Studies are few, sample sizes are relatively small, and methodological issues have not been adequately addressed. For example, can one effectively blind participants, therapists, and researchers for an honest comparison, as active placebos and psilocybin can be accurately distinguished by all three groups? Also, we do not know how psilocybin interacts with medications, including antidepressants, and supplements. With whom is psilocybin appropriate or contraindicated? Psilocybin has been proposed for treatment-resistant populations, but such populations often have comorbid disorders that may make them less appropriate for this kind of treatment. We do not know the background of volunteers for such research. Psilocybin's counterculture allure may lead to a pool of research participants who do not represent the population in general and, because of previous nonmedical use of psilocybin, have high expectations for benefitting from the treatment. We also do not know how "psychedelic therapists" will be trained, which may be especially important if psychedelics are eventually covered by insurance, where there will be an attempt to keep costs down. Finally, there is a potential for psychological side effects including delirium, panic attacks, depersonalization, and extreme distress (Ziff et al., 2022). Under controlled settings, some people experience transient elevated blood pressure, nausea, and vomiting. Some experience an onset of schizophrenia; although when psychosis persists, it is believed to be due to a predisposition rather than a drug-induced disorder.

Do No Harm

We want to do good, but the potential for harm is something that concerns each of us, especially as perceived harm (e.g., potential "bad trips" and boundary violations) often overpowers any benefits received. We should read and explore new ideas while still thoughtfully critiquing the research. Questioning new interventions is not being paternalistic; instead, this intellectual humility leads to more effective decision making (Sanchez & Dunning, 2021).

And, we need to remind our clients—and ourselves—that life often hurts and is difficult. There are no quick fixes for issues and life events that have no easy answers.

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CE QUESTIONS FOR THIS ISSUE

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Learning objectives: The articles in this issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

Introduction to the Endocannabinoid System

1. **How many different receptors of import are there in the endocannabinoid system?**
   a. 10
   b. 2
   c. 6
   d. 5

2. **Cannabidiol is also from the cannabis plant but does not have the same psychedelic effect as marijuana. However, it has been shown to help manage anxiety and improve seizure thresholds.**
   TRUE
   FALSE

"Should I Be Taking This Medication/Supplement?"

3. **When patients ask questions about medication, a psychologist's response may include which of the following while considering their ethical scope of practice?**
   a. Empathy
   b. Inquiry
   c. Consensus for a defined action
   d. All the above

4. **In addressing a patient's question about medication, a psychologist's response should involve:**
   a. The overall case conceptualization
   b. The APA Code of Ethics
   c. The patient's expectations of the medication's benefit on symptoms of concern
   d. All the above

Ketamine as a Treatment for Suicidal Behavior: Miracle or Mirage?

5. **Studies comparing ketamine with placebos have shown that it:**
   a. Significantly reduces suicidal thoughts more than placebos
   b. Significantly reduces suicidal behaviors more than placebos
   c. Significantly reduces suicidal thoughts and behaviors more than placebos
   d. Shows no benefit over placebo treatment

6. **Some of the unanswered questions about ketamine are whether it will:**
   a. Be effective with patients with a high risk of suicide
   b. Reduce suicidal behaviors as well as suicidal thoughts
   c. Be free of serious side effects if used over a prolonged period
   d. All the above

The Doors of Perception: Implications of Contemporary Psychedelic Research

7. **Cited research indicates that improvement in symptom distress under psilocybin administration is mediated by:**
   a. Mystical experience
   b. Emotional breakthrough
   c. Dopaminergic salience
   d. All the above
   e. a and b only

School Psychologists' Are Highly Qualified to Be School Board Directors: This Will Ultimately Benefit Students, Teachers, and Community Stakeholders

8. Based on the template matching process described in the article, what percentage of matched characteristics would be needed to indicate a high likelihood of an individual being successful in a new role or position?

a. 50 - 75%
b. 50 - 80%
c. 70 - 100%
d. 65 - 90%

Medical Marijuana: Advice for Schools

9. School nurses are qualified to oversee the administration of any student medications during the school day, to include medical marijuana, as long as the medication is sent to the school in the original prescription container.

TRUE
FALSE

10. Recommendations for schools regarding medical marijuana use by students includes all of the following except:

a. Provide a private location for the administration of medical marijuana
b. Allow a parent/guardian or caregiver to administer medical marijuana if a Patient Authorization Letter is provided
c. Verify that the prescribing physician has been approved to prescribe medical marijuana by the Department of Health
d. The parent/guardian/caregiver should not store medical marijuana in the school setting for student administration

MTSS In Higher Education

11. The developers of the MTSS system at Eastern University identified currently existing interventions that could be used in this model of student support.

TRUE
FALSE

Ethics in Action: Psychedelic-Assisted Treatment: More Questions Than Answers

12. Some of the unanswered questions with psilocybin treatment include whether:

a. Some people with comorbidities should be excluded
b. Side effects could be very severe
c. How it interacts with other medications or supplements
d. All the above

13. When considering a new treatment, psychologists should:

a. Eagerly embrace new treatments
b. Thoughtfully look at available research using the scientist-practitioner model
c. Wait until we are sure there are no negative effects
d. Be trained in the treatment before considering it

CONTINUING EDUCATION ANSWER SHEET

The Pennsylvania Psychologist, June 2023

Please circle the letter corresponding to the correct answer for each question.

1.	a	b	c	d	5.	a	b	c	d	9.	T	F	13.	a b c d
2.	T	F			6.	a	b	c	d	10.	a	b c d		
3.	a	b	c	d	7.	a	b	c	d e	11.	T	F		
4.	a	b	c	d	8.	a	b	c	d	12.	a	b c d		

Satisfaction Rating

Overall, I found this issue of *The Pennsylvania Psychologist:*

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Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

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How Prescribing Psychologists Could Save Lives in the Opioid Crisis
Live Webinar
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Thursday and Friday, October 5-6, 2023
PPA's VIRTUAL Fall Conference

November 30, 2023
License Renewal Deadline for Psychologists in Pennsylvania

Wednesday, June 12 – Saturday, June 15, 2024
PPA2024 Convention
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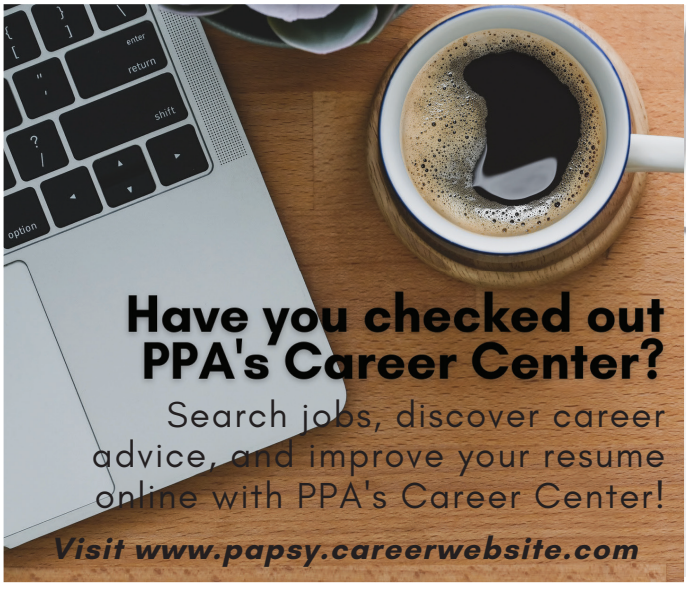

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Act 74 CE programs

Essential Competencies when Working with Suicidal Patients—1 CE
Four Ways to Enhance Your Suicide Assessments (Webinar)—1 CE
Talking about Suicide: The Patient's Experience and the Therapist's Experience (Webinar)—1 CE
The Assessment, Management, and Treatment of Suicidal Patients: 2020—3 CE
The Essentials of Managing Suicidal Patients: 2020—1 CE
The Essentials of Screening and Assessing for Suicide among Adolescents—1 CE
The Essentials of Screening and Assessing for Suicide among Adults—1 CE
The Essentials of Screening and Assessing for Suicide among Older Adults—1 CE
The Essentials of Treating Suicidal Patients—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version
Pennsylvania Child Abuse Recognition and Reporting—3 CE Version
Pennsylvania Child Abuse Recognition and Reporting (Webinar)—2 CE

General

Ethical Issues with COVID-19 (Webinar)—1 CE*
Ethical Responses when Dealing with Prejudiced Patients (Webinar)—1 CE*
Ethics and Self-Reflection—3 CE*
Foundations of Ethical Practice: Update 2019—3 CE*
Integrating Diversity in Training, Supervision, and Practice (Podcast)—1 CE
Interdisciplinary Collaboration in Assessing Capacity in the Elderly (Webinar)—1 CE
Introduction to Working with Chronic Health Conditions—3 CE
Legal and Ethical Issues with High Conflict Families—3 CE*
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Telepsychology Q&A (Webinar)—1 CE
Why the World is on Fire: Historical and Ongoing Oppression of Black African American People in the United States (Webinar)—1.5 CE

This program qualifies for contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

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